|  |  |
| --- | --- |
| UWA-primary%20athletic%20logo-RGB | **The University of West Alabama Athletic Department**  **Insurance Status Form for Student Athlete and Spouse**  **Athlete/Spouse to complete by TYPING or PRINTING with Black Ink Form # IS 2018-19** |

***PARTICIPATION WILL NOT BE ALLOWED UNTIL THIS FORM IS COMPLETED & RETURNED TO THE ATHLETIC DEPARTMENT***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of this Form:** | | | | | | |  | | | | | | **Athlete’s Social Security #** | | | | | | | | | | |  | | | | | | | | | | | | | | | | **Sport(s)** | | | |  | | | | | |
| **Athlete’s Full Name:** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | **Date of Birth** | | | | | |  | | | | | | | | | | | **Age** | | |  |
|  | | | | | | | | | **(Last) (First) (Middle)** | | | | | | | | | | | | | | | | | | | |  | | | | | | **(Month) (Day) (Year)** | | | | | | | | | | |  | | |  |
| **STUDENT ATHLETE INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name:** |  | | | | | | | | | | | | | | | | | | | | | | | | | | | **Phone #** | | | |  | | | | | | | | | |  |  | | | | | | |
|  | **(Last) (First) (Middle)** | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | **Mobile** | | | | | | | | | |  | **Home** | | | | | | |
| **Address** | |  | | | | | | | | | | | | |  |  | | | | | | | | | | | | | | | | | | | |  | |  | | | |  |  | | | |  |  | |
|  | | **Street or P.O. Box** | | | | | | | | | | | | |  | **City** | | | | | | | | | | | | | | | | | | | |  | | **State / Province** | | | |  | **Zip or Postal Code** | | | |  | **Country** | |
| **Primary email** | | |  | | | | | | | | | | | | | | | **Secondary email** | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| **Name of Employer** | | | | |  | | | | | | | | | | | | | | | **Employment Contact Person** | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| **Employer’s Address** | | | | | | | |  | | | | | | | | |  |  | | | | | | | | | | | | | | | | | |  | |  | | | |  |  | | | |  |  | |
|  | | | | | | | | **Street or P.O. Box** | | | | | | | | |  | **City** | | | | | | | | | | | | | | | | | |  | | **State / Province** | | | |  | **Zip or Postal Code** | | | |  | **Country** | |
| **Do you have Group Medical Insurance through your Employment?** | | | | | | | | | | | | | | | | | | |  | | **Yes** | |  | |  | | **No** | | | **Insurance Company:** | | | | | | | |  | | | | | | | | | | | |
| **Insurance Company Address** | | | | | |  | | | | | | | | | | |  |  | | | | | | | | | | | | | | | | | |  | |  | | | |  |  | | | |  |  | |
|  | | | | | | **Street or P.O. Box** | | | | | | | | | | |  | **City** | | | | | | | | | | | | | | | | | |  | | **State / Province** | | | |  | **Zip or Postal Code** | | | |  | **Country** | |
| **Insurance Company Phone#** | | | | | | | | | | |  | | | | | | **Policy#** | | | | |  | | | | | | | | | | | | | | **Group #** | | | | |  | | | | | | | | |
| **ID or Contract #** | | | |  | | | | | | | | | | | | | **Effective Date** | | | | | | | | |  | | | | | | | | | | **Expiration Date** | | | | | | | | |  | | | | |
| **SPOUSE INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name:** |  | | | | | | | | | | | | | | | | | | | | | | | | | | | **Phone #** | | | |  | | | | | | | | | |  |  | | | | | | |
|  | **(Last) (First) (Middle)** | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | **Mobile** | | | | | | | | | |  | **Home** | | | | | | |
| **Address** | |  | | | | | | | | | | | | |  |  | | | | | | | | | | | | | | | | | | | |  | |  | | | |  |  | | | |  |  | |
|  | | **Street or P.O. Box** | | | | | | | | | | | | |  | **City** | | | | | | | | | | | | | | | | | | | |  | | **State / Province** | | | |  | **Zip or Postal Code** | | | |  | **Country** | |
| **Primary email** |  | | | | | | | | | | | | | **Secondary email** | | | | | | |  | | | | | | | | | | | | | | | | **Date of Birth** | | | |  | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | **(Month) (Day) (Year)** | | | | | | | | | | | | | | |
| **Name of Employer** | | | | |  | | | | | | | | | | | | | | | **Employment Contact Person** | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| **Employer’s Address** | | | | | | | |  | | | | | | | | |  |  | | | | | | | | | | | | | | | | | |  | |  | | | |  |  | | | |  |  | |
|  | | | | | | | | **Street or P.O. Box** | | | | | | | | |  | **City** | | | | | | | | | | | | | | | | | |  | | **State / Province** | | | |  | **Zip or Postal Code** | | | |  | **Country** | |
| **Do you have Group Medical Insurance through your Employment?** | | | | | | | | | | | | | | | | | | |  | | **Yes** | |  | |  | | **No** | | | **Insurance Company:** | | | | | | | |  | | | | | | | | | | | |
| **Insurance Company Address** | | | | | |  | | | | | | | | | | |  |  | | | | | | | | | | | | | | | | | |  | |  | | | |  |  | | | |  |  | |
|  | | | | | | **Street or P.O. Box** | | | | | | | | | | |  | **City** | | | | | | | | | | | | | | | | | |  | | **State / Province** | | | |  | **Zip or Postal Code** | | | |  | **Country** | |
| **Insurance Company Phone#** | | | | | | | | | | |  | | | | | | **Policy#** | | | | |  | | | | | | | | | | | | | | **Group #** | | | | |  | | | | | | | | |
| **ID or Contract #** | | | |  | | | | | | | | | | | | | **Effective Date** | | | | | | | | |  | | | | | | | | | | **Expiration Date** | | | | | | | | |  | | | | |
| If you have medical insurance coverage and are not covered or only partially covered due to policy limitations, please explain: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **WITH MY SIGNATURE BELOW,**   1. I hereby authorize The University of West Alabama and any of its insurance companies and representatives to inspect or secure copies of case history record, laboratory reports, diagnosis, x-rays and other data covering this and/or previous confinements, and/or disabilities. A photostatic copy of this authorization shall be deemed as effective and valid as the original. 2. I authorize assignment to go directly to physician, hospital, radiologist, anesthesiologist, and rehabilitation services for medical services rendered to the above named athlete. A photostatic copy of this authorization shall be deemed as effective and valid as the original. 3. I agree that all information provided in this document is accurate and complete to the best of my knowledge. I understand that any incorrect or undisclosed information can result in duplicate payments creating a substantial over payment. The responsibility of such payment will be the responsibility of the undersigned to reimburse IN FULL, upon request, all amounts deemed refundable. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Student Athlete Signature:** | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | **Date** | | |  | | | | | | | | | | | | | | | |
| **Spouse Signature:** | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | **Date** | | |  | | | | | | | | | | | | | | | |
| **Return this form and a copy of the front and back of the insurance cards to**: | | | | | | | | | | | | Brad Montgomery, Station 14, UWA, Livingston, AL 35470 [bsm@uwa.edu](mailto:bsm@uwa.edu) (205) 652-3696 Office (205) 652-3799 Fax | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

|  |  |
| --- | --- |
| UWA-primary%20athletic%20logo-RGB | **The University of West Alabama Athletic Department**  **Insurance Status Form for Parent/Guardian of Student Athlete**  **Parent/Guardian to complete by TYPING or PRINTING with Black Ink Form # IS 2018-19** |

***PARTICIPATION WILL NOT BE ALLOWED UNTIL THIS FORM IS COMPLETED & RETURNED TO THE ATHLETIC DEPARTMENT***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of this Form:** | | | | |  | | | | | **Athlete’s Social Security #** | | | | | | | | | | |  | | | | | | | | | | | | | | | | **Sport(s)** | | | |  | | | | | |
| **Athlete’s Full Name:** | | | | | | |  | | | | | | | | | | | | | | | | | | | **Date of Birth** | | | | | |  | | | | | | | | | | | **Age** | | |  |
|  | | | | | | | **(Last) (First) (Middle)** | | | | | | | | | | | | | | | | | | |  | | | | | | **(Month) (Day) (Year)** | | | | | | | | | | |  | | |  |
| **FATHER/GUARDIAN INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name:** |  | | | | | | | | | | | | | | | | | | | | | | | | **Phone #** | | | |  | | | | | | | | | |  |  | | | | | | |
|  | **(Last) (First) (Middle)** | | | | | | | | | | | | | | | | | | | | | | | |  | | | | **Mobile** | | | | | | | | | |  | **Home** | | | | | | |
| **Address** | |  | | | | | | | | | |  |  | | | | | | | | | | | | | | | | | | | |  | |  | | | |  |  | | | |  |  | |
|  | | **Street or P.O. Box** | | | | | | | | | |  | **City** | | | | | | | | | | | | | | | | | | | |  | | **State / Province** | | | |  | **Zip or Postal Code** | | | |  | **Country** | |
| **Primary email** |  | | | | | | | | | | **Secondary email** | | | | | | |  | | | | | | | | | | | | | | | | **Date of Birth** | | | |  | | | | | | | | |
|  | | | | | | |  | | | | | | | | | | | | | | | | | | |  | | | | | | **(Month) (Day) (Year)** | | | | | | | | | | | | | | |
| **Name of Employer** | | | |  | | | | | | | | | | | | | **Employment Contact Person** | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| **Employer’s Address** | | | | | |  | | | | | | | |  |  | | | | | | | | | | | | | | | | | |  | |  | | | |  |  | | | |  |  | |
|  | | | | | | **Street or P.O. Box** | | | | | | | |  | **City** | | | | | | | | | | | | | | | | | |  | | **State / Province** | | | |  | **Zip or Postal Code** | | | |  | **Country** | |
| **Do you have Group Medical Insurance through your Employment?** | | | | | | | | | | | | | | | |  | | **Yes** | |  | |  | | **No** | | | **Insurance Company:** | | | | | | | |  | | | | | | | | | | | |
| **Insurance Company Address** | | | | |  | | | | | | | | |  |  | | | | | | | | | | | | | | | | | |  | |  | | | |  |  | | | |  |  | |
|  | | | | | **Street or P.O. Box** | | | | | | | | |  | **City** | | | | | | | | | | | | | | | | | |  | | **State / Province** | | | |  | **Zip or Postal Code** | | | |  | **Country** | |
| **Insurance Company Phone#** | | | | | | | |  | | | | | | **Policy#** | | | | |  | | | | | | | | | | | | | | **Group #** | | | | |  | | | | | | | | |
| **ID or Contract #** | | |  | | | | | | | | | | | **Effective Date** | | | | | | | | |  | | | | | | | | | | **Expiration Date** | | | | | | | | |  | | | | |
| **MOTHER/GUARDIAN INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name:** |  | | | | | | | | | | | | | | | | | | | | | | | | **Phone #** | | | |  | | | | | | | | | |  |  | | | | | | |
|  | **(Last) (First) (Middle)** | | | | | | | | | | | | | | | | | | | | | | | |  | | | | **Mobile** | | | | | | | | | |  | **Home** | | | | | | |
| **Address** | |  | | | | | | | | | |  |  | | | | | | | | | | | | | | | | | | | |  | |  | | | |  |  | | | |  |  | |
|  | | **Street or P.O. Box** | | | | | | | | | |  | **City** | | | | | | | | | | | | | | | | | | | |  | | **State / Province** | | | |  | **Zip or Postal Code** | | | |  | **Country** | |
| **Primary email** |  | | | | | | | | | | **Secondary email** | | | | | | |  | | | | | | | | | | | | | | | | **Date of Birth** | | | |  | | | | | | | | |
|  | | | | | | |  | | | | | | | | | | | | | | | | | | |  | | | | | | **(Month) (Day) (Year)** | | | | | | | | | | | | | | |
| **Name of Employer** | | | |  | | | | | | | | | | | | | **Employment Contact Person** | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| **Employer’s Address** | | | | | |  | | | | | | | |  |  | | | | | | | | | | | | | | | | | |  | |  | | | |  |  | | | |  |  | |
|  | | | | | | **Street or P.O. Box** | | | | | | | |  | **City** | | | | | | | | | | | | | | | | | |  | | **State / Province** | | | |  | **Zip or Postal Code** | | | |  | **Country** | |
| **Do you have Group Medical Insurance through your Employment?** | | | | | | | | | | | | | | | |  | | **Yes** | |  | |  | | **No** | | | **Insurance Company:** | | | | | | | |  | | | | | | | | | | | |
| **Insurance Company Address** | | | | |  | | | | | | | | |  |  | | | | | | | | | | | | | | | | | |  | |  | | | |  |  | | | |  |  | |
|  | | | | | **Street or P.O. Box** | | | | | | | | |  | **City** | | | | | | | | | | | | | | | | | |  | | **State / Province** | | | |  | **Zip or Postal Code** | | | |  | **Country** | |
| **Insurance Company Phone#** | | | | | | | |  | | | | | | **Policy#** | | | | |  | | | | | | | | | | | | | | **Group #** | | | | |  | | | | | | | | |
| **ID or Contract #** | | |  | | | | | | | | | | | **Effective Date** | | | | | | | | |  | | | | | | | | | | **Expiration Date** | | | | | | | | |  | | | | |
| If you have medical insurance coverage and are not covered or only partially covered due to policy limitations, please explain: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **WITH MY SIGNATURE BELOW,**   1. I hereby give consent/permission for my son/daughter as named above to participate fully in the above named varsity sport(s) at The University of West Alabama beginning with the year of date of this form and beyond. 2. I hereby authorize The University of West Alabama and any of its insurance companies and representatives to inspect or secure copies of case history record, laboratory reports, diagnosis, x-rays and other data covering this and/or previous confinements, and/or disabilities. A photostatic copy of this authorization shall be deemed as effective and valid as the original. 3. I authorize assignment to go directly to physician, hospital, radiologist, anesthesiologist, and rehabilitation services for medical services rendered to the above named athlete. A photostatic copy of this authorization shall be deemed as effective and valid as the original. 4. I agree that all information provided in this document is accurate and complete to the best of my knowledge. I understand that any incorrect or undisclosed information can result in duplicate payments creating a substantial over payment. The responsibility of such payment will be the responsibility of the undersigned to reimburse IN FULL, upon request, all amounts deemed refundable. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Father/Guardian Signature:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | **Date** | | |  | | | | | | | | | | | | | | | |
| **Mother/Guardian Signature:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | **Date** | | |  | | | | | | | | | | | | | | | |
| **Student Athlete Signature:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | **Date** | | |  | | | | | | | | | | | | | | | |
| **Return this form and a copy of the front and back of the insurance cards to**: | | | | | | | | | Brad Montgomery, Station 14, UWA, Livingston, AL 35470 [bsm@uwa.edu](mailto:bsm@uwa.edu) (205) 652-3696 Office (205) 652-3799 Fax | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

|  |  |
| --- | --- |
| UWA-primary%20athletic%20logo-RGB | **The University of West Alabama Athletic Department**  **Athletic Medical Expense Payment Procedure** |

All medical bills for the athlete incurred as the result of an injury in the intercollegiate sports program should be sent directly to the athlete or to the athlete’s home address. In some cases, the Athletic Department may receive a bill, but in no case will the Athletic Department be the primary place for the bill incurred to be charged. Athletes incurring medical expenses as a result of participation in the University of West Alabama Athletic Program should follow the procedure below in regards to the handling of their medical bills.

1. Submit all of the medical bills incurred to your family or employer group coverage first. This will result in one or more of the following actions:
   1. Your insurance company or parent’s employer may ask for more information regarding the patient, enrollment in college, injury, treatment, hospitalization, etc. If this is the case, it is your responsibility to forward this information to your insurance company. If we can assist in obtaining this information, we will be glad to do so.
   2. Your insurance company may honor the claim and pay all or a portion of the bills incurred. As a result, they usually provide you with an Explanation of Benefits (EOB). Please forward a copy of this to us with any remaining medical bills.
   3. Your insurance company may not honor the claim and send you a denial of benefits letter. An example might be that the athlete is no longer part of the group policy after attaining the age of twenty-six. If so, please forward a copy of this to us.

1. If a balance remains after your family or employer group insurance has contributed towards the claim, send the Explanation of Benefits (EOB) from the insurance company and a copy of the bills incurred to Brad Montgomery at the UWA Athletic Department.  
     
   If you receive a denial of benefits letter from your family or employer group insurance carrier, then send the denial of benefits letter and a copy of the bills incurred to Brad Montgomery at the UWA Athletic Department.
2. If you do not have any insurance at all, then ask your employer to write a letter stating that you are not covered by any group insurance with the company. Forward this letter and a copy of the bills incurred to Brad Montgomery at the UWA Athletic Department.
3. Our athletic insurance may require that you and/or your parents complete a claim form or other forms that we will forward to you. We will not accept financial responsibility for these medical charges until you comply with these requests.

Address all correspondence to: Brad Montgomery, Head Athletic Trainer

UWA Station 14

Livingston, AL 35470

Phone (205) 652-3696

Fax (205) 652-3799

[bsm@uwa.edu](mailto:bsm@uwa.edu)